STATE OF MICHIGAN

COURT OF APPEALS

CARL STONE and NANCY STONE, Plaintiffs-Appellees/Cross-Appellants, v DAVID A. WILLIAMSON, M.D., JACKSON RADIOLOGY CONSULTANTS, P.C., and W. A. FOOTE MEMORIAL HOSPITAL, Defendants-Appellants/Cross-Appellees.	UNPUBLISHED April 17, 2007 No. 265048 Jackson Circuit Court LC No. 03-001912-NH

Before: Servitto, P.J., and Talbot and Schuette, JJ.

PER CURIAM.

Defendants, David A. Williamson, M.D., Jackson Radiology Consultants, P.C., and W. A. Foote Memorial Hospital, appeal as of right entry of judgment following a jury verdict in this action for medical malpractice. Plaintiffs, Carl and Nancy Stone, as husband and wife, on cross-appeal seek amendment of the judgment to include prejudgment interest on the amount of case evaluation sanctions imposed. We affirm, but remand to the trial court for recalculation of prejudgment interest.

Carl Stone was 62 years of age and had a history of atherosclerotic vascular disease, hypertension and elevated cholesterol in January 2000, when he also began to experience pain in his lower extremities. Carl had been married to his wife, Nancy, for over 35 years and worked part-time as a heavy equipment mechanic. Carl was referred by his family physician, Marvin Fields, M.D., to vascular surgeon, David Eggert, M.D., to evaluate his physical complaints. Dr. Eggert noted a lack of circulation in Carl's lower extremities and ordered an arteriogram be performed. Dr. Eggert detected diminished pulses in Carl's lower extremities and believed the patient could have right femoral artery stenosis.

Dr. Eggert arranged for Carl to have an arteriogram performed by Jackson Radiology Consultants, located at W. A. Foote Memorial Hospital on January 25, 2000. David A.

Williamson, M.D., a radiologist, performed the arteriogram.[1] During the arteriogram, Dr. Williamson inserted a catheter through Carl's left groin, into the abdominal aorta, and injected dye. Following the dye injection, a series of x-rays were taken to evaluate the blood vessels and flow. Dr. Williamson identified a severe occlusion in Carl's right femoral and iliac arteries and contacted Dr. Eggert for permission to perform an angioplasty. Dr. Eggert gave Dr. Williamson permission to perform the angioplasty and the procedure was successfully completed.

Dr. Williamson reviewed the x-ray films from the procedure and authored a report, which was forwarded to Dr. Eggert. Dr. Williamson's report indicated:

> There is marked arteriosclerosis of the infrarenal abdominal aorta but no aneurysm.

Carl reported alleviation of discomfort in his extremities following the angioplasty.[2] After the angioplasty, Carl was seen by three additional physicians, including: Dr. Mark Zande, a cardiologist, in July 2001; Dr. Madhu Aroura, a rheumatologist in January 2002; and his family physician, Dr. Marvin Fields in February 2002. Each of these physicians performed clinical physical examinations, which did not detect the presence of an abdominal aneurysm on manual palpation. Carl consulted with Dr. Fields in late 2001 due to complaints of generalized pain and was diagnosed with polymyalgia rheumatica (PMR), which led to his referral to Dr. Aroura.

On April 4, 2002, Carl suffered the rupture of an abdominal aortic aneurysm, which measured approximately 8.4 centimeters, requiring emergency surgery. Carl was admitted to W. A. Foote Memorial Hospital and Gregory Casey, M.D., performed the emergency rupture repair. Dr. Casey indicated that Carl experienced leg clots as a result of the rupture, interfering with blood flow to his lower extremities. Because Carl was hemodynamically unstable, Dr. Casey could not immediately return him to the operating room to restore blood flow to his legs. After the operation, Carl suffered renal failure and acute respiratory failure, necessitating intubation and ventilatory support. Four days later, on April 8, 2002, Carl returned to the operating room for amputation of both legs at the mid-thigh level. Shortly thereafter, due to the development of gangrene in the left stump, Dr. Casey performed another operative procedure, which resulted in hip disarticulation and debridement of the necrosis in Carl's left upper leg. During this period, Carl continued to experience multi-organ failure and other complications, including acute renal failure, sepsis, rhabdomyolysis, osteomyelitis, recurrent pancreatitis and depression. Carl remained hospitalized for approximately four months, not including a one-month stay at a local hospital rehabilitation unit. Upon return to his home, Carl required structural changes to his

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[1] Dr. Williamson is a partner in Jackson Radiology Consultants, P.C., and a member of W. A. Foote Memorial Hospital's medical staff.

[2] Notably, Dr. Eggert's prior physical examination of Carl, which included palpation of the abdominal area, did not detect the presence of an aneurysm. However, it is unclear from the transcripts whether Dr. Eggert performed another clinical examination of Carl after the angioplasty.

residence to accommodate his wheelchair and specialized needs. His wife, Nancy, quit her employment to assist in the daily care needs of her husband.

At trial, plaintiff presented three expert radiologists[3], who all opined that Dr. Williamson violated the standard of care by failing to properly identify the existence of curvilinear lines on the arteriogram x-ray films as calcifications of the abdominal aorta denoting the existence of an aneurysm of at least five centimeters in size. The physicians all concurred that the presence of an aneurysm of five centimeters or greater requires further diagnostic tests and, typically, results in elective surgery to correct the aneurysm due to the increasing risk of rupture as the aneurysm grows. Plaintiffs contended that if Dr. Williamson had properly identified the aneurysm, elective surgery could have been performed greatly increasing Carl's potential for a better medical outcome, including the reduction of risk for amputation and other health complications.

At trial and during deposition, Dr. Williamson acknowledged the presence of the curvilinear line on the x-ray could indicate calcification and, therefore, a possible aneurysm. However, Dr. Williamson indicated that the referral by Dr. Eggert did not specifically seek diagnosis regarding existence of an aneurysm and that the abnormality was too subtle to identify at the time of the evaluation and without the benefit of hindsight provided by the eventual rupture. In the alternative, Dr. Williamson asserted the aneurysm did not exist at the time of the angioplasty and, rather, the aneurysm developed much later and grew unusually fast based on Carl's underlying compromised vascular system and other existing medical problems, including his diagnosis of polymyalgia rheumatica. Dr. Williamson argued that this theory was further supported by the failure of three other physicians to detect the presence of the aneurysm subsequent to the angioplasty during clinical examination.

The jury returned a verdict in favor of plaintiffs in the total amount of $2,327,835.00. Following reduction for the damages cap and collateral sources, a judgment was entered on June 2, 2005, in the amount of $1,936.682.00, comprising $1,640,800.00 for the verdict, and the remainder for interest costs and attorney fees. The trial court denied defendants' post judgment motions for a new trial and judgment notwithstanding the verdict.

This Court reviews a trial court's decision on a motion for JNOV de novo. *Sniecinski v BCBSM*, 469 Mich 124, 131; 666 NW2d 186 (2003). This Court must view the evidence and all legitimate inferences in the light most favorable to the nonmoving party, *id.*, to determine whether a question of fact existed. *Zantel Marketing Agency v Whitesell Corp*, 265 Mich App 559, 568; 696 NW2d 735 (2005).

Defendants contend plaintiffs failed to meet the burden that the delay in diagnosis of Carl Stone's aneurysm and resultant emergency surgery resulted in a lost opportunity to achieve a better result by 50 percent as required by MCL 600.2912a(2). Specifically, defendants argue the trial court erred in holding that the relevant calculation of the lost opportunity for a better result was the difference between the combined abstract risk of all possible, but unrealized complications such as death, contrasted to the risks for elective surgery for this condition.

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[3] Robert Vogelzang, M.D., Michael Potchen, M.D., and Michael Foley, M.D.

Rather, defendants argue that the trial court should have restricted proofs to the difference between an opportunity for a better result with elective surgery absent the malpractice and the opportunity for the specific better result lost by this plaintiff, involving bilateral amputation. In other words, defendants take issue with the broader risks included in the calculation of Carl Stone's lost opportunity for a better result to include risk factors other than those actually realized or incurred. In addressing defendants' motion for summary disposition, the trial court indicated defendant's interpretation of *Fulton v William Beaumont Hosp,* 253 Mich App 70; 655 NW2d 569 (2002) was overly restrictive, ruling:

> I think it has to be referred to be looking at the risk of—and not of the specific—I may be using the term lower extremity, occlusion, I'm not sure of the medical term, but this amputation, I'm using it, you know, but it has to be looked at in terms of the chances of having a good result versus the chances of having a bad result. And I'm convinced that the testimony is sufficient to establish there's more than a 50 percent decrease, and that would include both this type of serious complication, death, and maybe there's other types of serious complications. But I think you include them all.

The trial court reiterated its ruling in response to defendants' motion for new trial or JNOV, stating:

> But in this case, we get the—there's an increased chance of dying, significant increased chance of dying; there's increased chance of some complications. It seems to me that the only way that you can give this text any real under—meaningful interpretation is that you have to include the bad results; that is, what's the chance of, you know, getting on the table and being okay and—when you're done.

The parties dispute the meaning of MCL 600.2912a(2), which states:

> In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants. In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%.

This Court previously determined that the second sentence of this statutory subsection was ambiguous and necessitated interpretation. *Fulton, supra* at 80. In *Fulton,* the Court rejected *Wickens v Oakwood Healthcare Sys,* 465 Mich 53, 54, 60-62; 631 NW2d 686 (2001), which required the demonstration that "the premalpractice opportunity to survive" exceeded 50 percent in favor of "requir[ing] a plaintiff to show that the loss of the opportunity to survive or achieve a better result exceeds fifty percent." In other words, the loss of opportunity did not comprise the "initial opportunity to survive," but rather the difference in opportunity, which occurred because of medical negligence.

Part of the confusion arises from the Court's ruling in *Wickens* "that a living person may not recover for loss of an opportunity to survive, and that plaintiff's claim is therefore barred to

the extent that it is based on such loss of opportunity." *Wickens, supra* at 54. However, *Wickens* can be factually distinguished because it dealt with preclusion against recovery for reduced life expectancy as being too speculative. Specifically, the Court determined that:

> The plain language of the statute, therefore, expressly limits recovery to injuries that have already been suffered and more probably than not were caused by the defendant's malpractice. Thus, plaintiff can only recover for a present injury, not for a potential future injury . . . . Thus, a loss of an opportunity to survive claim only encompasses injuries already suffered, which clearly limits recovery to situations where death has already occurred. [*Id.* at 60-61.]

In sum, the Court ruled, "a living plaintiff may not recover for loss of an opportunity to survive on the basis of a decrease in her chances of long-term survival," which translates as a claim for reduction in life expectancy because of the speculative nature of such a claim. *Id.* at 62.

Plaintiffs' medical experts testified that a patient having elective surgery to repair an aortic aneurysm has a 95 percent of attaining a good result, which includes the potential to survive the rupture as well as avoiding additional medical complications. In contrast, misdiagnosed patients whose aneurysms rupture have only a ten percent chance to achieve a good result. Specifically, Drs. Eggert, Casey, Flanigan and Rimar all opined that 80 percent of patients with aortic aneurysm ruptures die, typically en route to obtain medical care. Of those patients that successfully reach the hospital, 60 percent die during the surgery. Of the 20 percent of patients who rupture that manage to survive, 40 to 50 percent have some form of complication contrasted to those who undergo elective repair, who face less than a five percent risk of dying or suffering serious complications. Notably, Dr. Flanigan also opined that Carl's chance of amputation was less than one percent with an elective repair compared to the actual risk of amputation of 100 percent, which occurred due to the rupture. Defendants contend that the testimony is insufficient to meet the requirements of MCL 600.2912a(2), because if the risk of death is factored out, Carl's chance of realized complications resulted in only a loss of opportunity for a better result of 35 percent, thus failing to meet the 50 percent threshold.

Defendants are incorrect in their assertion that consideration or inclusion of the risk of death as part of the calculation of a plaintiff's "opportunity to achieve a better result" is precluded by the wording of MCL 600.2912a(2). Although the language of the statute differentiates between the "loss of an opportunity to survive" and the "opportunity to achieve a better result," the "loss of an opportunity to survive" has been specifically interpreted to mean a reduction in life expectancy and not to exclusively encompass the risk of death. Hence, the risk of death is separate and distinguishable from the "loss of an opportunity to survive."

The trial court properly recognized that the myriad of complications and risks, including the potential for death, comprise a patient's "opportunity to achieve a better result." The trial court correctly permitted comparison of the difference in all risk factors faced by Carl between elective and emergency surgery, including the risk of death and other medical complications, in determining his "opportunity to achieve a better result." A good result in this case is inextricably tied to the possibility of death and the difference between the risks inherent in elective surgery versus emergency surgery. In accordance with *Fulton*, the trial court was required to determine the difference between the overall risks faced by Carl from the ruptured aneurysm as compared to the risk of undergoing elective surgery had the malpractice not occurred. In either situation,

the potential to die was a risk that had to be included in the comparison between surgical procedures. Any other outcome would fail to recognize the actual risks confronted because of the malpractice and would penalize plaintiff for surviving the rupture.

The analysis used by the trial court met the requirements of the statutory language because it was restricted solely to plaintiff's "opportunity to achieve a better result." The risk of death comprised a factor intrinsically tied to this plaintiff's opportunity to attain a better medical outcome. As such, the trial court's inclusion of the risk of death in determining that plaintiffs met the requirements of MCL 600.2912(a)(2) and its subsequent instruction to the jury were not in error.

Defendants also contend the failure of plaintiffs' subsequent treating physicians, who conducted physical or clinical examinations of Carl after completion of procedures by Dr. Williamson comprise intervening or superseding causes which negate Dr. Williamson's liability for malpractice. Specifically, defendants note that three subsequent physicians examined Carl and failed to detect the presence of an aneurysm. Although defendants primarily asserted this failure to detect the presence of an aneurysm by the subsequent clinicians demonstrated that an aneurysm did not exist, defendants alternatively assert that the failure to detect the aneurysm shifts liability to these other physicians.

Although an intervening cause may sometimes relieve a defendant from liability, *McMillan v Vliet*, 422 Mich 570, 576; 374 NW2d 679 (1985), an intervening cause is not an absolute bar to liability if it is foreseeable. *Taylor v Wyeth Laboratories, Inc*, 139 Mich App 389, 402; 362 NW2d 293 (1984). An intervening cause is defined as one, which actively operates to produce harm to someone after the negligence of the defendant. *McMillan, supra* at 586. Consequently, when a defendant's negligence consisted of enhancing the likelihood that the intervening cause would occur or consisted of a failure to protect the plaintiff against the risk that did occur, the intervening cause is considered to be reasonably foreseeable. *Id.* at 586. Whether a physician's intervening negligent act constitutes a superseding proximate cause constitutes a question for the jury. *Richards v Pierce*, 162 Mich App 308, 317; 412 NW2d 725 (1987).

In this instance, plaintiffs produced testimony indicating that clinical examination is not a reliable method to ascertain the presence of an aneurysm. For instance, Dr. D. Preston Flanigan, a vascular surgeon, opined that "a lot of times [aneurysms] are not felt," and that "less than half of aneurisms are palpable in a physical exam." Dr. Michael Potchen, a radiologist, concurred, "aneurisms are notoriously difficult to feel and to follow clinically." Dr. Potchen noted that a variety of factors could also influence the ability of a physician to detect an aneurysm on clinical examination, including but not limited to the patient's size and ability to relax, the location of the aneurysm, as well as familiarity with the patient's body habitus.

Defendants presented contrary testimony, which affirmed the ability of a trained physician to detect the presence of an aneurysm, particularly an aneurysm of the size asserted by plaintiffs prior to rupture. However, this testimony was used primarily to suggest that the aneurysm did not exist or was not of the size postulated at the time of the radiological films produced and interpreted by Dr. Williamson and not to assert the breach of the standard of care by plaintiffs' subsequent treating physicians for failing to detect the aneurysm upon clinical examination. Importantly, defendants did not present evidence proving a breach of the

applicable standard of care by any of these subsequent physicians. Whether these subsequent treaters were negligent in failing to diagnose the existence of an aneurysm solely through their clinical evaluations of Carl was ultimately a jury question that was not resolved in defendants' favor. Ultimately, the determination of whether Carl's aneurysm could or should have been detected upon clinical examination became a matter of credibility between experts. This Court will not interfere or disturb the weighing of evidence or credibility determinations made by the jury. *Central Cartage Co v Fewless*, 232 Mich App 517, 524; 591 NW2d 422 (1998).

Further, the mere fact these physicians allegedly perpetuated the diagnostic error is insufficient to shift the burden of liability. The subsequent treating physicians had a right to rely on Dr. Williamson's affirmative report statement that an aneurysm did not exist. As such, any purported malpractice or negligence by these subsequent treaters is foreseeable because Dr. Williamson's medical opinion that the condition did not exist enhanced the likelihood that the aneurysm would not be detected and, thus, would not absolve Dr. Williamson's liability. "An act of negligence does not cease to be a proximate cause of the injury because of an intervening act of negligence, if the prior negligence is still operating and the injury is not different in kind from that which would have resulted from the prior act." *Taylor, supra* at 401-402.

Defendants had the opportunity to identify the subsequent treating physicians as either third-party defendants or non-parties at fault in accordance with MCR 2.204(A) and MCR 2.112(K)(3), but failed to do so. The failure to properly plead the concurrent or intervening liability of these physicians, coupled with the absence of expert testimony by medical personnel of the same specialty as the identified physicians to establish their violation of the applicable standard of care in failing to diagnose the aneurysm precludes defendants' attempt to shift liability from Dr. Williamson and the named defendants.

Defendants next assert the trial court erred in precluding the testimony of two surgeons regarding their reading and interpretation of x-ray films produced by Dr. Williamson regarding the presence or absence of an aneurysm. This Court reviews a trial court's rulings concerning the qualifications of a proposed expert witness to testify for an abuse of discretion. *Woodard v Custer*, 476 Mich 545, 557; 719 NW2d 842 (2006).

In a medical malpractice action, the qualifications of a standard of care expert are governed by MCL 600.2169, which provides, in relevant part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the *appropriate* standard of practice or care unless *the person* is licensed as a health professional in this state or another state and meets the following criteria:
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> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in *the same specialty* as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in *that specialty.*

> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a *majority* of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of *that specialty*.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in *the same specialty*. [Emphasis added.][4]

The initial requirement of MCL 600.2169(1)(a) is that "[I]f a party against whom or on whose behalf the testimony is offered is a specialist, [the expert witness must have] specialize[d] at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered." In other words, "if a defendant physician is a specialist, the plaintiff's expert witness must have specialized in the same specialty as the defendant physician at the time of the alleged malpractice." *Woodard, supra* at 560-561.

In this case, Dr. Williamson is a board certified radiologist. However, defendants sought to use the testimony of Drs. Eggert and Rimar, as general and vascular surgeons, regarding their interpretations and ability to discern the existence of an aneurysm from the x-ray films produced by Dr. Williamson. Plaintiffs sought, through a motion in limine, to preclude this testimony, asserting it was proscribed under MCL 600.2192 and that only board certified radiologists could testify regarding whether Dr. Williamson violated the standard of care by failing to detect or diagnose the presence of an aneurysm. Defendants objected asserting the testimony was being offered on the issue of proximate cause and not standard of care. As observed by the trial court this alleged distinction is merely semantic, because the issues were "inseparable," and provision of a cautionary instruction would be inadequate and would require the "jury to almost do the impossible." The trial court did not restrict the testimony of these physicians regarding the detectability of the alleged aneurysm on physical examination and indicated it would permit defendants to substitute a radiologist as a witness. In explaining its reasoning the trial court emphasized:

> I think it's going to be impossible for a jury to distinguish between these two issues when it is the identical issue of the aneurism being there and since he cannot testify as to the standard of care, I find that the probative value substantially outweighs the – is substantially outweighed by the prejudicial effect.

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[4] MCL 600.2169(1) is only applicable to expert testimony regarding the appropriate standard of care or practice; the subsection is not applicable to other kinds of expert testimony, including expert testimony on causation.

This is consistent with prior rulings of this Court, indicating that evidence may be excluded if its probative value is substantially outweighed by the danger of prejudice, confusion of the issues, misleading the jury, undue delay, waste of time, or needless presentation of cumulative evidence. *Dunn v Nundkumar*, 186 Mich App 51, 55; 463 NW2d 435 (1990); MRE 403.

The trial court's ruling is consistent with the mandate of MCL 600.2169(1)(b), which requires an expert witness to have "devoted a majority of his professional time during the year immediately preceding the date on which the alleged malpractice occurred to practicing or teaching the specialty that the defendant physician was practicing at the time of the alleged malpractice." *Woodard*, *supra* at 566. In this instance, the presence or absence of an aneurysm on the radiological films is inextricably tied to the issue of standard of care. Hence, the trial court did not abuse its discretion by ruling that testimony by non-radiologists was not admissible regarding interpretation of the radiological films because such evidence would have impermissibly violated the mandate of MCL 600.2169 regarding the qualifications of an expert, as well as MRE 403.

In addition, defendants contest the trial court's ruling, following a *Davis-Frye* hearing, precluding the presentation of testimony on defendants' theory that Carl's aneurysm was rapidly growing and expanded five centimeters in less than two months. Defendants sought to introduce testimony through Drs. Femminineo and Rimar regarding a rapid growth theory. Defendants asserted that Carl had been assessed with polymyalgia rheumatica in late 2001. Approximately 15 percent of patients with polymyalgia rheumatica also have giant cell arteritis. Patients with giant cell arteritis have an increased potential for developing an abdominal aortic aneurysm that will grow larger than the average growth rate of approximately one-half centimeter a year. Defendants therefore contend that because the treating physicians did not detect Carl's aneurysm during clinical examination the aneurysm must have grown from a smaller size in February 2002 of 3 to 3.5 centimeters to 8.4 centimeters in April 2002, suggesting an exponential growth rate of five centimeters in just over a one-month period. Specifically, Dr. Femminineo opined:

> [I]t's been well documented that this individual has a vasculopathy to begin with. He has atherosclerosis, he has a history of hypertension, hyperlipidemia, genetic predisposition, smoking history and then a new onset of a rheumatologic condition that has a strong association with vasculitis. The combination, in my opinion, played a role in that rapid expansion.

Plaintiffs sought exclusion of the testimony, asserting it was not admissible in accordance with MRE 702 because this theory was not based on sufficient facts or data and was not the product of reliable scientific principles and methods. Plaintiffs further contended that the testimony failed to meet the threshold requirements of the *Davis-Frye* test, which requires that expert opinion based on a novel scientific theory is admissible only if the underlying science, theory and methodology is generally accepted within the scientific community. Plaintiffs contended that defendants' theory failed to meet the demonstrable facts of this case and was not recognized or supported within medical literature.

Plaintiffs presented the testimony of Dr. Flanigan, a vascular surgeon, who provided and discussed a number of authoritative medical articles, which disputed that the existence of polymyalgia rheumatica impacted the growth or development of abdominal aortic aneurysms and opined that the relationship between rapid growth abdominal aortic aneurysms and polymyalgia

rheumatica was "not a known medical thing." Plaintiffs further presented studies and testimony pertaining to patients with abdominal aortic aneurysms, including some individuals with polymyalgia rheumatica, showing that the average growth rate for an aneurysm is less than one-half centimeter a year. Dr. Flanigan disputed the existence of any evidence to demonstrate that Carl's aneurysm grew at a rate of more than one-half to one centimeter a year, which coincided with the testimony of plaintiffs' expert radiologists who opined that the clinical evidence regarding Carl's aneurysm was consistent with this typical rate of growth based, in part, on their determination that Carl's aneurysm was approximately five centimeters in size in the radiological films produced by Dr. Williamson. Plaintiffs addressed defendants' theory that the aneurysm must have grown at an exceptional rate based on the failure of several treating physicians to discover its presence on physical examination by presenting testimony by Dr. Flanigan that clinical examination is not a reliable method to detect the presence of an aneurysm and that aneurysms are often missed on clinical examination.

In addition, plaintiffs presented the testimony of an expert radiologist, Dr. Robert Vogelsang, regarding defendant's theory that Carl's polymyalgia rheumatica led to giant cell arteritis, and in turn developed into a rapidly expanding aneurysm. Dr. Vogelsang opined that Carl did not have giant cell arteritis based on the absence of symptoms of that disease and further, that presentation of Carl's aneurysm, as observed on the radiological films and other clinical evidence, was consistent with a slow growing calcified aneurysm. Specifically, Dr. Vogelsang rejected that theory that Carl's aneurysm was the result of rapid growth related to giant cell arteritis because of the density of calcification, which requires time to develop. Dr. Foley concurred with this testimony, indicating that the calcification of Carl's aneurysm had existed for an extended time period and was not consistent with polymyalgia rheumatica. The absence of giant cell arteritis as a diagnosed condition for Carl was addressed in conjunction with the testimony of Dr. Femminineo regarding deficiencies in the medical literature presented in support of defendants' theory of rapid growth expansion of the aneurysm.

At the conclusion of the *Davis-Frye* hearing, the trial court ruled:

> Now I think there's a connection between PMR and giant cell arteritis. I think that's supported by the literature. There's some instance of aneurism there, but there's nothing that connects either of these with this type of rapidly expanding aneurism. That seems to me to be a novel theory and I don't think it has to be something just with, you know, something that looks exactly like Mr. Stone. And even a single case study wouldn't be – would be interesting, but there isn't anything, must less a whole population study. Not even a single case where some has suggested this happened, or believes this happened.
>
> I think the theory that these conditions could cause a rapidly expanding aortic aneurism is – does not have that acceptance in the community and is not allowed under 702, so I'm going to – I'm not sure if it was really sort of a motion to strike, but I'm exercising my function under 702 and I will not allow that testimony.
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> * * *

> I'm not saying they can't testify it wasn't there, they did a physical exam, they say it isn't there, they can certainly can say it isn't there. I'm not striking that testimony at all, but to say it's my theory that it expanded in the last two months due to these factors, I don't think there's any – I think there has to be some support that that can happen and I haven't heard any of that.

The trial court did not preclude the introduction of testimony on this theory if defendants could present acceptable scientific data or support for the rapid growth and expansion during the course of trial.

MRE 702 governs a trial court's decision whether to allow proposed scientific expert testimony into evidence, providing:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

Notably the amendment of MRE 702 has resulted in replacement of the *Davis-Frye* test with the test elucidated in *Daubert v Merrill Dow Pharmaceuticals, Inc,* 509 US 579; 113 S Ct 2786; 125 L Ed 2d 469 (1993). See *Gilbert v Daimler Chrysler Corp,* 470 Mich 749, 781; 685 NW2d 391 (2004). Although *Gilbert* acknowledged that the standards contained in *Daubert* now governed the admission of expert testimony, the Court reiterated the trial judge's gatekeeper function, noting that the change merely permitted the trial judge to expand the number of factors to be considered, beyond "general acceptance," in determining admissibility of expert opinion evidence. *Gilbert, supra* at 781-782. Some of the factors identified by *Daubert* for consideration include, but were not necessarily limited to, whether the theory or technique that served as the basis for the expert opinion: (1) had been or can be tested; (2) "has been subjected to peer review and publication"; (3) has a high "known or potential rate of error"; and (4) has a "general acceptance" within the scientific community. *Daubert, supra* at 593-595. As such, application of these factors necessitates that the trial court's focus "must be solely on principles and methodology, not on the conclusions that they generate." *Id.* at 595.

In addition, the admissibility of scientific expert testimony is governed by MCL 600.2955, which states:

> (1) In an action for the death of a persons or for injury to a person or property, a scientific opinion rendered by an otherwise qualified expert is not admissible unless the court determines that the opinion is reliable and will assist the trier of fact. In making that determination, the court shall examine the opinion and the basis for the opinion, which basis includes the facts, technique, methodology, and reasoning relied on by the expert, and shall consider all of the following factors:

a) Whether the opinion and its basis have been subjected to scientific testing and replication.

(b) Whether the opinion and its basis have been subjected to peer review publication.

(c) The existence and maintenance of generally accepted standards governing the application and interpretation of a methodology or technique and whether the opinion and its basis are consistent with those standards.

(d) The known or potential error rate of the opinion and its basis.

(e) The degree to which the opinion and its basis are generally accepted within the relevant expert community. As used in this subdivision, "relevant expert community" means individuals who are knowledgeable in the field of study and are gainfully employed applying that knowledge on the free market.

(f) Whether the basis for the opinion is reliable and whether experts in that field would rely on the same basis to reach the type of opinion being proffered.

(g) Whether the opinion or methodology is relied upon by experts outside of the context of litigation.

(2) A novel methodology or form of scientific evidence may be admitted into evidence only if its proponent establishes that it has achieved general scientific acceptance among impartial and disinterested experts in the field.

(3) In an action alleging medical malpractice, the provisions of this section are in addition to, and do not otherwise affect, the criteria for expert testimony provided in section 2169.

Problematically, defendants' theory of a rapidly growing or expanding aneurysm does not meet the statutory requirements. The evidence proffered by Dr. Femminineo predominantly pertains to the facts, which underlie his medical opinion and not the principles, and methods on which he relied to interpret the facts to support his medical conclusion. The publications relied on in support of this theory although linking the presence of certain physiological conditions to aneurysms do not sufficiently address either their applicability to actual diagnoses for Carl Stone or to extremely rapid growth aneurysms. Defendants failed to establish that Femminineo's causation theory had been tested, subjected to peer review and publication, or is generally accepted within the medical community. Notably, any links demonstrated by Dr. Femminineo's testimony and the proffered literature between aneurysm growth and giant cell arteritis are irrelevant, given the failure of Carl Stone to have this diagnosis. Clearly, the circuit court understood its role in evaluating the evidence in support of this causation theory and did not abuse its discretion when it precluded testimony on this theory in accordance with MRE 702 and MCL 600.2955.

Defendants also assert that Nancy Stone was not entitled to an award of wage loss as damages under her loss of consortium claim. Loss of consortium is a derivative action. *Wilson v*

Alpena Co Rd Comm, 474 Mich 161, 163 n 1; 713 NW2d 717 (2006). "Loss of consortium technically means the loss of conjugal fellowship." This encompasses loss of society, companionship, affection, services, and all other incidents of the marriage relationship. *Kucken v Hygrade Food Prod Corp*, 51 Mich App 471, 474-475; 215 NW2d 772 (1974). As such, loss of consortium has been defined as a noneconomic loss. *Jenkins v Patel*, 471 Mich 158, 168; 684 NW2d 346 (2004), citing *Rusinek v Schultz, Snyder & Steele Lumber Co*, 411 Mich 502, 504-505; 309 NW2d 163 (1981).

Although defendants are correct that Nancy Stone's lost wages comprise an economic loss and not a noneconomic damage as contemplated by a loss of consortium claim, they are foreclosed from now asserting this error based on their affirmation of the jury instructions and verdict form, which included Nancy Stone's claim for lost wages, resulting in waiver. It is well established that error requiring reversal cannot be error to which the aggrieved party contributed by plan or negligence. *Phinney v Perlmutter*, 222 Mich App 513, 527; 564 NW2d 532 (1997). This was recognized and properly ruled on by the trial court in denying defendants' motion for JNOV. Because defendants expressly indicated approval of the jury instructions and verdict form, any objection was waived. *Chastain v GMC*, 254 Mich App 576, 591-592; 657 NW2d 804 (2002). See also, *Hilgendorf v St John Hosp and Medical Ctr Corp*, 245 Mich App 670, 696; 630 NW2d 356 (2001); *Phinney, supra* at 537.

The trial court also determined that "[t]he loss of services . . . is an economic claim that the caps don't apply to." This is consistent with MCL 600.1483(3) which defines "noneconomic loss" to mean "damages or loss due to pain, suffering, inconvenience, physical impairment, physical disfigurement, or other noneconomic loss." The damages disputed are for the replacement costs incurred by Nancy Stone to secure household or home services previously provided by her husband. Because this is the replacement cost of such services, the award comprises an economic claim that is not subject to the cap imposed by MCL 600.1483.

Defendants challenge the jury's determination regarding the existence of an ostensible agency. Despite indication from the trial court that the evidence on the issue of ostensible agency was tenuous, the matter was submitted to the jury, which imposed liability. The trial court denied defendants' motion for JNOV, indicating that the existence of an ostensible agency relationship was "based on . . . Mr. Stone, who's not a sophisticated person . . . understanding [he was] referred to Foote."

"Generally speaking, a hospital is not vicariously liable for the negligence of a physician who is an independent contractor and merely uses the hospital's facilities to render treatment to his patients. However, if the individual looked to the hospital to provide him with medical treatment and there has been a representation by the hospital that medical treatment would be afforded by physicians working therein, an agency by estoppel can be found." *Grewe v Mt Clements Gen Hosp*, 404 Mich 240, 250-251; 273 NW2d 429 (1978). The Court in *Grewe* noted:

> The relationship between a given physician and a hospital may well be that of an independent contractor performing services for, but not subject to, the direct control of the hospital. However, that is not of critical importance to the patient who is the ultimate victim of that physician's malpractice. [*Id.* at 252.]

Rather, the Court identified the critical issue to be "whether the plaintiff, at the time of his admission to the hospital, was looking to the hospital for treatment of his physical ailments or merely viewed the hospital as the situs where his physician would treat him for his problems." *Id.* at 251. A factor relevant to this determination is whether the hospital provided the plaintiff with Dr. Williamson or whether the plaintiff and Dr. Williamson had a physician-patient relationship independent of the hospital setting.

In the circumstances of this case, Carl was referred by his family physician to Dr. Eggert, a vascular surgeon. Due to diagnostic concerns revealed through Dr. Eggert's clinical examination, he referred Carl to Foote Hospital's Diagnostic Center and not a specific physician for radiological evaluation. As such, Carl indicated his understanding that the procedure he was to undergo was to be performed at and by Foote Hospital. There was no pre-existing physician-patient relationship with Dr. Williamson or any other practitioner at that location. There was no indication provided to Carl by Foote Hospital to inform him that Dr. Williamson or Jackson Radiology Consultants, P.C. were independent contractors. Defendants have demonstrated nothing, which would distinguish their practice as functioning independently or separately from the Hospital.

This case is factually similar to *Setterington v Pontiac Hosp,* 223 Mich App 594; 568 NW2d 93 (1997). In *Setterington*, the plaintiff was referred by her treating physician to the hospital for a series of CT scans. Despite repeated scans, radiologists did not detect or opine to the treating physician that plaintiff's condition could be cancerous and, as a result, plaintiff's condition went undiagnosed and plaintiff died following metastasis of the cancer. In *Setterington*, the jury determined that the plaintiff did not have a physician-patient "relationship with the radiologists independent of the hospital setting. Rather the radiologists just happened to be on duty when [the plaintiff] arrived at the hospital. Moreover, the evidence showed that the radiology department is held out as part of the hospital, leading patients to understand that the services are being rendered by the hospital." *Id.* at 603.

"An agency is ostensible when the principal intentionally or by want of ordinary care, causes a third person to believe another to be his agent who is not really employed by him." *Grewe, supra* at 252 (citation omitted). The elements of an ostensible agency are identified as including:

> (1) the person dealing with the agent must do so with the belief in the agent's authority and this belief must be a reasonable one, (2) the belief must be generated by some act or neglect on the part of the principal sought to be charged, and (3) the person relying on the agent's authority must not be guilty of negligence. [*Chapa v St Mary's Hosp of Saginaw*, 192 Mich App 29, 33-34; 480 NW2d 590 (1991).]

In this instance, defendants did nothing to provide Carl with notice that the radiological services being provided were not a part of Foote Hospital or that Dr. Williamson was an independent contractor and not an employee of the Hospital. As "[a]gency is always a question of fact for the jury," the record demonstrates that plaintiff looked to the Hospital for the services rendered and was treated by medical personnel who were the ostensible agents of the Hospital, thus providing support for the jury's finding. *Grewe, supra* at 253.

Finally, on cross-appeal, plaintiffs assert this Court should remand this matter to the trial court for entry of an amended judgment adding prejudgment interest for the case evaluation sanctions in accordance with *Ayar v Foodland Distributors,* 472 Mich 713; 698 NW2d 875 (2005). In the lower court, defendants did not challenge the holding of *Ayar* but rather disputed the amount of interest calculated by plaintiffs and the absence of the trial court's jurisdiction to amend the judgment based on the issue being raised after expiration of the proper time period for amendment. "A trial court's decision whether to grant case evaluation sanctions under MCR 2.403(O) presents a question of law, which this Court reviews de novo." *Campbell v Sullins,* 257 Mich App 179, 197; 667 NW2d 887 (2003).

At the time of entry of the Judgment on June 2, 2005, the trial court ordered postjudgment interest to be paid from the date of entry of the judgment until the judgment was paid. Notably, following entry of the judgment, the Michigan Supreme Court issued its ruling in *Ayar,* holding:

> [MCL 600.6013(8)] plainly states that interest on a money judgment is calculated from the date of filing the complaint. We find this language to be clear and unambiguous, as we did in [*Morales v Auto-Owners Ins Co (After Remand),* 469 Mich 487; 672 NW2d 849 (2003).] In *Morales,* we concluded that the statute makes no exception for periods of prejudgment appellate delay, and that interest on a judgment following such a delay is calculated, without interruption, from the date the complaint is filed. Similarly, the statute makes no exception for attorney fees and costs ordered as mediation sanctions under MCR 2.403(O).
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> We conclude that, under MCL 600.6013(8), judgment interest is applied to attorney fees and costs ordered as mediation sanctions under MCR 2.403(O) from the filing of the complaint against the liable defendant. This results from a plain reading of the statute. [*Ayar, supra* at 716-718.]

Defendants merely assert that application of *Ayar* and the Supreme Court's interpretation of MCL 600.6013 would be unfair given the existence of this Court's decision in the predecessor case of *Ayar v Foodland Distributors,* 263 Mich App 105; 687 NW2d 365 (2004) that did not permit imposition of such sanctions, and on which defendants relied in rejecting the case evaluation determination. Contrary to defendants' assertion, judicial decisions are typically given full retroactive effect. *Holmes v Michigan Capital Med Ctr,* 242 Mich App 703, 713; 620 NW2d 319 (2000). "Prospective application is a departure from the usual rule and is appropriate only in 'exigent circumstances.'" *Devillers v Auto Club Ins Ass'n,* 473 Mich 562, 586; 702 NW2d 539 (2005) (citation omitted). Prospective application is typically reserved for decisions that serve to overrule clear and uncontradicted case law, *id.* at 587, or decisions ruling on an issue of first impression, the resolution of which was not clearly foreshadowed or anticipated. *Lindsey v Harper Hosp,* 455 Mich 56, 68; 564 NW2d 861 (1997). Factors which have been identified for consideration following determination that a decision clearly established a new principle of law include: (1) the purpose to be served by the new rule, (2) the extent of reliance on the old rule, and (3) the effect of retroactive application on the administration of justice. *Pohutski v City of Allen Park,* 465 Mich 675, 696; 641 NW2d 219 (2002).

The Supreme Court in deciding *Ayar* indicated that its interpretation of MCL 600.6013(8) derived from the plain language of the statute. Because the Court found the statute to be plain and unambiguous, *Ayar* cannot be construed to involve or establish a new principle of law. Hence, retroactive application of *Ayar* is appropriate, requiring the judgment to be remanded to the trial court for recalculation and inclusion of the revised amount of prejudgment interest.

We affirm, but remand to the trial court for recalculation of prejudgment interest pursuant to *Ayar*. We do not retain jurisdiction.

/s/ Deborah A. Servitto
/s/ Michael J. Talbot
/s/ Bill Schuette